Adolescent Sleep Habits Survey

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Purpose A structured survey featuring both open-ended and multiple-choice questions. Intended as a clinical tool, the instrument allows for the collection of demographic details, familial and medical histories, and information regarding sleep habits, schedules, and behaviors [1]. Three versions of the survey have been created: two designed for self-report (differing only in their mention of either male- or female-related developmental milestones), and one for the adolescent's parent or guardian to complete.

Population for Testing Age range is less of an issue for this survey since it is not intended to be a standardized measure – any youth considered an "adolescent" may be surveyed, though the questionnaire itself specifically refers to grades 4 through 12.

Administration All three versions are pencil-and-paper instruments, consisting of between 61 and 65 questions – each version should require between 20 and 30 min for completion. When choosing whether to administer the self-report or parent version, consider the different foci of the two tests: Parents/guardians may be able to provide more detailed developmental histories and important third-party observations of behaviors (e.g., snoring), while self-reports allow the patients themselves to clarify personal sleep preferences and habits.

Reliability and Validity Designed simply as a tool for collecting qualitative information, the psychometric properties of the scale have not been analyzed.

Obtaining a Copy All three versions can be found at http://www.kidzzzsleep.org

Reprint requests should be directed to:
Dr. Judith Owens
Rhode Island Hospital, Division of Pediatric Ambulatory Medicine
593 Eddy Street, Potter Building, Suite 200
Providence, RI 02903, USA
Telephone: (401) 444-8280
Email: owensleep@aol.com

Scoring The survey was developed predominantly as an instrument for screening, and is not often used in research as its open-ended format precludes attempts at standardization. Since interpretation of the survey's answers requires at least some training in sleep medicine, the questionnaire is largely used by sleep specialists to gain an overall understanding of the familial, medical, and behavioral history of patients presenting at specialized clinics.

A. Shahid et al. (eds.), *STOP, THAT and One Hundred Other Sleep Scales,*
DOI 10.1007/978-1-4419-9893-4_1,

TODAY'S DATE: ____/____/____

PARENT QUESTIONNAIRE

SCHOOL-AGED CHILDREN (4-12 years old)

PEDIATRIC SLEEP CLINIC QUESTIONNAIRE (4-12 YEAR OLDS)

1. Name of Patient: _____ 2. Date of Birth:___/___/___
3. Name of person completing questionnaire _____
   Relationship to child _____
   Referred by _____
   Pediatrician _____
4. A copy of the sleep clinic evaluation will be sent to you, your pediatrician, and any referring physician. Please indicate anyone else who should receive a copy:
   Name: _____ Address: _____
   _____
5. What are your major concerns about your child's sleep? _____
   _____
   _____
6. What do you think is causing your child's sleep problem? _____
   _____
7. When did your child's sleep problems start? _____
   _____

FAMILY INFORMATION

8. Please list all members of the households in which your child lives full or part-time:

Name/Relationship to Child	Age	Child lives with (please indicate full-time or part-time)

9. Mother's Marital Status: Married Divorced Separated Widowed Single
   If divorced, child custody with: _____
10. Mother's education: _____
11. Mother's occupation: _____
    Does mother work outside of home? ☐ yes ☐ no
    If yes, mark each label that best describes her work:
    - ☐ day shift
    - ☐ evening shift
    - ☐ night shift (graveyard)
    - ☐ changing shifts
    - ☐ full time
    - ☐ part time
    - ☐ one job
    - ☐ more than one job

12. Fathers's Marital Status: Married Divorced Separated Widowed Single
If divorced, child custody with: _____
13. What is father's education: _____
14. Father's occupation: _____
Does father work outside of home? ☐ Yes ☐ No

If yes, mark each label that best describes his work:

☐ day shift	☐ full time
☐ evening shift	☐ part time
☐ night shift (graveyard)	☐ one job
☐ changing shifts	☐ more than one job

15. What best describes your child's racial/ethnic background?

White/Caucasian_____ Asian/Asian American _____

Black/African American _____ Native American _____

Hispanic/Latino _____ Multiracial (Please specify)_____

Other (Please specify)_____

16. Please list family members (parents, grandparents, siblings, aunts/uncles) with a history of any SLEEP PROBLEMS (including: loud snoring/obstructive sleep apnea, excessive sleepiness/ narcolepsy, restless legs/periodic leg movements, insomnia, other sleep problems).

Family Member	Type of Sleep Problem
_____	_____
_____	_____
_____	_____
_____	_____

17. Has anyone in your family ever had a car accident caused by sleepiness (not due to alcohol or drugs)? Yes ☐ No ☐ Don't know ☐

If yes, whom: _____ At what age: _____

Type of accident: _____

18. Please list any family members with a significant mental health condition (such as depression, anxiety, alcoholism/substance abuse).

Family Member	Type of Mental Health Problem
_____	_____
_____	_____
_____	_____

SLEEP HISTORY (GENERAL)

19. What time does your child usually go to bed on school nights? _____

Range: _____ am/pm to _____am/pm

20. What is the main reason your child goes to bed at a particular time? (Check one below)

_____ a. Because it fits best with the family's schedule
_____ b. Because she/he feels sleepy then
_____ c. Because that is when her/his TV shows are over
_____ d. Because that is when her/his brothers and sisters go to bed
_____ e. To "get enough sleep" for the following day's activities
_____ f. Other (describe briefly)_____

21. What time does your child usually wake up on school day mornings? _____

Range: _____ am/pm to _____am/pm

22. What usually wakes up your child in the morning on school days? (Check one below)

_____ a. Alarm clock
_____ b. Parent or other family member
_____ c. Noise
_____ d. Needs to go to the bathroom
_____ e. Spontaneous
_____ f. Other (describe briefly):

23. Which of the following applies to waking your child in the morning on school days? (Check one below)

_____ a. I almost always have great difficulty getting him/her out of bed
_____ b. I sometimes have great difficulty getting him/her our of bed
_____ c. I seldom have great difficulty getting him/her out of bed
_____ d. I never have great difficulty getting him/her out of bed

24. What times does your child usually go to bed on weekend nights? _____

Range: _____ am/pm to_____am/pm

25. What time does your child usually wake up on weekend mornings? _____

Range: _____ am/pm to _____am/pm

26. What usually wakes up your child in the morning on weekends? (Check one below)

_____ a. Alarm clock
_____ b. Parent or other family member
_____ c. Noise
_____ d. Needs to go to the bathroom
_____ e. Spontaneous
_____ f. Other (describe briefly):

27. Which of the following applies to waking your child in the morning on weekends? (Check one below)

_____ a. I almost always have great difficulty getting him/her out of bed
_____ b. I sometimes have great difficulty getting him/her our of bed
_____ c. I seldom have great difficulty getting him/her out of bed
_____ d. I never have great difficulty getting him/her out of bed

28. IN AN AVERAGE TWO-WEEK PERIOD, HOW OFTEN DOES YOUR CHILD ...
(Check one answer for each question; please feel free to comment)

	Every day/ night	5-6 times	3-4 times	1-2 times	Never	Comments:
snore?	☐	☐	☐	☐	☐	
snore loudly and disruptively?	☐	☐	☐	☐	☐	
sleep restlessly?	☐	☐	☐	☐	☐	
sleep in an abnormal position?	☐	☐	☐	☐	☐	
sweat while sleeping?	☐	☐	☐	☐	☐	
pause in breathing	☐	☐	☐	☐	☐	
complain of headache on waking?	☐	☐	☐	☐	☐	
have nightmares?	☐	☐	☐	☐	☐	
sleepwalk?	☐	☐	☐	☐	☐	
sleeptalk?	☐	☐	☐	☐	☐	
cry out during sleep?	☐	☐	☐	☐	☐	
wake up at night?	☐	☐	☐	☐	☐	
get out of bed at night?	☐	☐	☐	☐	☐	
complain about his/her sleep?	☐	☐	☐	☐	☐	
complain of pain at night?	☐	☐	☐	☐	☐	
wet the bed?	☐	☐	☐	☐	☐	

29. Has your child ever used medication (over-the-counter or prescription) including herbal or "natural" remedies to help with sleep?

Yes ☐ No ☐ Don't know ☐

If yes, name of medication and how frequently used: _____

Does your child currently (within the past month) use medications (over-the-counter or prescription) to help with sleep? Yes ☐ No ☐ Don't know ☐

If yes, name of medication and how frequently used: _____

SLEEP HISTORY - DAYTIME SLEEPINESS

30. During the LAST TWO WEEKS, has your child struggled to stay awake (fought sleep) or fallen asleep in the following situations? (Mark one answer for every item)

	No	Struggled to stay awake (fought sleep)	Fallen asleep	Don't Know	Does not Apply
a. in a face-to-face conversation with another person?	☐	☐	☐	☐	☐
b. traveling in a car, bus?	☐	☐	☐	☐	☐
c. at the movies?	☐	☐	☐	☐	☐
d. watching television?	☐	☐	☐	☐	☐
e. listening to the radio or stereo?	☐	☐	☐	☐	☐
f. reading, studying or doing homework?	☐	☐	☐	☐	☐
g. in a class at school?	☐	☐	☐	☐	☐
h. while doing work on a computer?	☐	☐	☐	☐	☐
i. playing video games?	☐	☐	☐	☐	☐
j. eating a meal?	☐	☐	☐	☐	☐

MEDICAL HISTORY:

31. Were there any problems with this pregnancy or delivery (prematurity, high blood pressure, etc.)? _____

_____

32. What was the birth weight? _____

33. Was your child ever on an apnea monitor at home? Yes ☐ No ☐

If yes, for how long? _____

34. Does your child have any significant health problems? Yes ☐ No ☐

If so, please describe: _____

_____

35. Has your child ever been hospitalized? Yes ☐ No ☐

If yes, when: _____ What for? _____

_____ _____

_____ _____

36. Has your child ever had any operations (other than tonsils/adenoids removal)?

Yes ☐ No ☐

If yes, type of operation? _____ Year _____

_____ Year _____

_____ Year _____

37. Have your child's tonsils or adenoids been removed?

a. Tonsils: Yes ☐ At what age?_____

For what reason: _____

b. Adenoids: Yes ☐ At what age?_____

For what reason: _____

c. Describe briefly any changes you noticed in your child's sleep or waking behavior after removal of tonsils or adenoids:

_____

38. If NO, do you think the tonsils or adenoids are a problem? Yes ☐ No ☐ Don't know ☐
For how long have they been a problem? _____ years

39. Has your child ever broken his/her nose or other facial bones? Yes ☐ No ☐

40. Does your child have difficulty breathing through his/her nose? Yes ☐ No ☐

41. In the past year, has your child had strep throats/tonsillitis? Yes ☐ No ☐

Frequent colds/respiratory infections? Yes ☐ No ☐

Frequent sinus infections? Yes ☐ No ☐

42. Does your child have allergies? Yes ☐ No ☐ Possibly ☐

If yes, to what?_____

43. Does your child have asthma? Yes ☐ No ☐ If "Yes", please answer the following questions:

In the **past year**....

a. How many days has your child missed school due to asthma? _____ None ☐

b. How many days has your child been hospitalized for asthma? _____ None ☐

c. List any medications your child takes for asthma:

Type: _____ Frequency: _____

Type: _____ Frequency: _____

Type: _____ Frequency: _____

44. Does your child frequently complain of heartburn? Yes ☐ No ☐ Don't know ☐

Has he/she ever been diagnosed with gastroesophageal (stomach) reflux?

Yes ☐ No ☐ Only when younger ☐

45. Has your child had any head injuries requiring medical evaluation and/or treatment or loss of consciousness? If yes, please describe:_____

46. List any prescription or over-the counter medications your child has taken in the last month:

Type: _____ Reason for medication: _____

Type: _____ Reason for medication: _____

Type: _____ Reason for medication: _____

47. Do you have additional comments about your child's medical history? (Continue on additional sheets if necessary.)

_____

_____

_____

HEALTH HABITS - Please answer the following questions regarding health habits which may impact on sleep. In the past 2 weeks, on average:

48. How much caffeinated soda did your child drink?

- ☐ More than 3 glasses per day
- ☐ Between 1 and 3 glasses per day
- ☐ Less than one glass per day
- ☐ None
- ☐ Don't know

49. How much television and/or videos did your child watch on school days?

☐ 0-2 hours per day ☐ between 2 and 4 hours ☐ between 4 and 6 hours
☐ between 6 and 8 hours ☐ more than 8 hours ☐ don't know

a. How much time does your child spend on the computer on school days?

☐ 0-2 hours per day ☐ between 2 and 4 hours ☐ between 4 and 6 hours
☐ between 6 and 8 hours ☐ more than 8 hours ☐ don't know

How much television and/or videos did your child watch on weekend days?

☐ 0-2 hours per day ☐ between 2 and 4 hours ☐ between 4 and 6 hours
☐ between 6 and 8 hours ☐ more than 8 hours ☐ don't know

a. How much time does your child spend on the computer on weekend days?

☐ 0-2 hours per day ☐ between 2 and 4 hours ☐ between 4 and 6 hours
☐ between 6 and 8 hours ☐ more than 8 hours ☐ don't know

50. Did your child watch TV and/or videos in the 30 minutes before falling asleep?

- ☐ every night
- ☐ 5-6 nights
- ☐ 3-4 nights
- ☐ 1-2 nights
- ☐ not at all

51. Does your child have a television set in his/her bedroom? Yes ☐ No ☐

DEVELOPMENT HISTORY- PART A

52. In what grade is your child currently enrolled? _____ grade

53. What school does your child attend this year?_____

54. Has your child been diagnosed with:

	YES	NO	COMMENTS
a. dyslexia	☐	☐	_____
b. a speech impairment	☐	☐	_____
c. mental retardation	☐	☐	_____
d. a behavior disorder	☐	☐	_____
e. attention deficit disorder	☐	☐	_____
f. other learning disorder (please specify)_____	☐	☐	_____

55. Is your child enrolled in any special education (special needs) classes in school?

☐ Yes ☐ No Please describe:

_____

56. Does your child have an Individualized Education Plan (I.E.P.) provided by the school?

☐ Yes ☐ No If yes, for what reason:

_____

57. Generally, how often does your child attend school?
    a. ☐ Every day
    b. ☐ 3-4 days per week
    c. ☐ 1-2 days per week
    d. ☐ Less than once per week

58. Generally, how often is your child late to school?
    a. ☐ Every day
    b. ☐ 3-4 days per week
    c. ☐ 1-2 days per week
    d. ☐ Less than once per week

DEVELOPMENTAL HISTORY- PART B

59. Does your child have any significant behavioral or mental health problems? Yes ☐
No ☐
If yes, please describe _____

_____

60. Has your child ever received counseling for behavioral or mental health problems?
Yes ☐ No ☐ If so, for what reason?

_____

Please give approximate dates:

_____

61. Have you or your spouse ever been seen by a mental health counselor for concerns regarding your child? Yes ☐ No ☐
If yes, for what reason? _____

62. To what organized groups does your child currently belong? (e.g., team sports, scouts, church, groups, etc.) _____

_____

SLEEP BELIEFS

In order to better understand your sense of the average child's sleep, please answer the following questions based on your beliefs for an average child (your child's age) who does not have sleep problems?

a. How many hours of sleep per night does the average child need? _____ hours
b. How many hours of sleep per night does the average child get? _____ hours
c. How long does it take the average child to get to sleep? _____ minutes
d. How many times does the average child wake up during the night? _____ times
e. How long does the average child spend awake in bed during the night?
_____ minutes or _____ hours
f. Do you think most children get enough sleep? Yes ☐ No ☐ Don't Know ☐

THANK YOU VERY MUCH FOR YOUR TIME!

ADOLESCENT SLEEP HABITS SURVEY
(BOY'S SELF REPORT)

Instructions: This form should be filled out by the adolescent patient himself if at all possible.
Today's Date: _____/_____/_____

1. Name:_____2. Date of Birth: ____/____/____
3. Please describe your sleep problem(s): _____
_____
_____

4. How long have you had difficulty with sleep? (check one)
☐ less than a month ☐ 1-6 months
☐ 6-12 months ☐ 1-5 years
☐ more than 5 years

5. Have your problems with sleep gotten worse? ☐ Yes ☐ No ☐Not sure
If yes, when did you notice that your sleep problems got worse: _____

6. What do you think is causing your sleep problem? (check all that apply)
☐ stress at school ☐ relationship problems with parents/family
☐ relationship problems with peers ☐ poor sleep habits
☐ poor eating habits ☐ a physical problem
Other (describe briefly)_____

SLEEP HABITS: This set of questions asks about your usual sleep habits. Please answer as honestly as possible.

7. With whom do you share a bedroom? (check all that apply)

	Yes	No
Mother/step-mother	☐	☐
Father/step-father	☐	☐
Older brother(s)/sister(s)	☐	☐
Younger brother(s)/sister(s)	☐	☐
Other family member(s).....	☐	☐

8. In the last two weeks, have you slept in the same bed?
☐ every night ☐ almost every night
☐ a few nights ☐ not at all

The next set of questions has to do with your usual schedule on days when you have school. Please list both the USUAL times or number of hours/minutes, and the RANGE (earliest to latest, lowest to highest). Please check AM or PM for each time.

9. What time do you **usually** go to bed on school days? _____
Range: _____ ☐ AM/ ☐ PM to _____ ☐ AM/ ☐ PM

SLEEP HABITS (continued)

10. There are many reasons for doing things at one time or another. What is the **main reason** you usually go to bed at this time on school days? (check one)

☐ My parents have set my bedtime
☐ I finish my homework
☐ My brother(s) or sister(s) go to bed
☐ I get home from my job
☐ I feel sleepy
☐ My TV shows are over
☐ I finish socializing
☐ Other: _____

11. What time do you **usually** wake up on school days? _____
Range: _____ ☐AM/ ☐PM to _____ ☐AM/ ☐ PM

12. There are many reasons for doing things at one time or another. What is the **main reason** you usually wake up at this time on school days? (check one)

☐ Noises or my pet wakes me up
☐ My parents wake me up
☐ I don't know, I just wake up
☐ My alarm clock wakes me up
☐ I need to go to the bathroom
☐ Other: _____

13. What time do you **usually** leave home on school days? _____
Range: _____ ☐AM/ ☐ PM to _____ ☐AM/ ☐ PM

14. How do you usually get to school? (check one)
☐ Walk ☐ Take the bus ☐ Get a ride with parent
☐ Get a ride with friend(s) ☐ Drive my car

What time do you need to arrive at school? _____

15. Figure out how long you **usually** sleep on a normal school night and fill it in here. (Do not include time you spend awake in bed. Remember to mark hours and minutes, even if minutes are zero.)
Usual amount of sleep: _____ hours and_____ minutes
Range: _____ hours and_____ minutes to _____ hours and_____ minutes

16. On school days, after you go to bed at night, about how long does it usually take you to fall asleep? (If longer than one hour, change to minutes.)
Usual amount: _____ minutes
Range: _____ minutes to _____ minutes

The next set of questions has to do with your usual schedule on days when you DO NOT have school, such as the weekend.

17. What time do you **usually** go to bed on weekends? _____
Range: _____ ☐AM/ ☐PM to _____ ☐AM/ ☐ PM

18. There are many reasons for doing things at one time or another. What is the **main reason** you usually go to bed at this time on **weekends**? (check one)
☐My parents have set my bedtime
☐ I finish my homework
☐ My brother(s) or sister(s) go to bed
☐ I get home from my job
☐ I feel sleepy
☐ My TV shows are over
☐ I finish socializing
☐ Other: _____

SLEEP HABITS (continued)

19. What time do you **usually** wake up on weekends? _____ ☐AM/ ☐PM
Range: _____ ☐ AM/ ☐PM to _____ ☐AM/ ☐ PM

20. What is the **main reason** you usually wake up at this time on weekends? (check one)
☐ Noises or my pet wakes me up
☐ My alarm clock wakes me up
☐ My parents wake me up
☐ I need to go to the bathroom
☐ I don't know, I just wake up
☐ Other: _____

21. Figure out how long you **usually** sleep on a night when you do not have school the next day (such as a weekend night) and fill it in here. (Do not include time you spend awake in bed. Remember to mark hours and minutes, even if minutes are zero.)
Usual amount of sleep: _____ hours and_____ minutes
Range: _____ hours and_____ minutes to _____ hours and_____ minutes

22. On weekends, after you go to bed at night, about how long does it usually take you to fall asleep? (If longer than one hour, change to minutes.)
Range: _____ minutes to _____ minutes

23. Can you figure out how much sleep you need? Fill out how much sleep you think you would need each night to feel your best every day. (Do not include time you spend awake in bed. Remember to mark hours and minutes, even if minutes are zero.)
_____ hours _____ minutes

The following questions ask about other sleep habits you may have. Please answer as honestly as possible.

24. In the last two weeks, how often have you done any of the following activities in bed?

	Every day/night	Several times	Twice	Once	Never
Read?	☐	☐	☐	☐	☐
Watch TV?	☐	☐	☐	☐	☐
Eat?	☐	☐	☐	☐	☐
Do schoolwork?	☐	☐	☐	☐	☐
Worry?	☐	☐	☐	☐	☐

25. When you have difficulty falling asleep or getting back to sleep, what do you do? (check all that apply)
☐ Stay in bed and try to get to sleep
☐ Do something in bed (e.g., read or watch TV)
☐ Get up and watch TV
☐ Get up and drink alcohol
☐ Get up and drink warm milk
☐ Get up and drink something? (circle all that apply: soda/water/coffee/tea)
☐ Get up and have a cigarette
Other (please specify): _____

SLEEP HABITS (continued)

26. Please circle a number from 1-10 to indicate how much difficulty you have relaxing away tension in your body while trying to sleep.

0	1	2	3	4	5	6	7	8	9	10
No Difficulty					Some Difficulty					Great Difficulty

27. Please circle a number from 1-10 to indicate how much difficulty you have in "slowing down" or "turning off" your mind while trying to sleep.

0	1	2	3	4	5	6	7	8	9	10
No Difficulty					Some Difficulty					Great Difficulty

28. Do you currently use medications (over-the-counter or prescription) to help you sleep?
☐Yes ☐ No

If yes, how often (check one):
☐ once a month or less ☐ once a week or less ☐ few times a week ☐ nightly

Please list any medications you are currently using (within the past month) to help you sleep:

Name of Medication	Amount	How long have you used this medicine?	Meds make you feel		
			Better	No Change	Worse
_____			☐	☐	☐
_____			☐	☐	☐
_____			☐	☐	☐

If you are not currently using medication to help you sleep, have you ever used medication in the past (over-the-counter or prescription) to help you sleep? ☐ Yes ☐ No

If yes, list any medications you used to help you sleep:

Name of Medication	Amount	How long did you use medicine?	Meds make you feel		
			Better	No Change	Worse
_____			☐	☐	☐
_____			☐	☐	☐
_____			☐	☐	☐

SLEEP HISTORY (GENERAL)

29. In an average 2 week period, how often do you... (Check **ONE** answer for each question)

	Every day/night	5-6 times	3-4 times	1-2 times	Never	Don't know
need more than one reminder to get up in the morning?	☐	☐	☐	☐	☐	☐
arrive late to class because you overslept?	☐	☐	☐	☐	☐	☐
fall asleep in a morning class?	☐	☐	☐	☐	☐	☐
fall asleep in a afternoon class?	☐	☐	☐	☐	☐	☐
feel tired, dragged out, or sleepy during the day?	☐	☐	☐	☐	☐	☐
go to bed because you just could not stay awake any longer?	☐	☐	☐	☐	☐	☐
sleep in past noon?	☐	☐	☐	☐	☐	☐
stay up until at least 3 am?	☐	☐	☐	☐	☐	☐
stay up all night?	☐	☐	☐	☐	☐	☐
have an extremely hard time falling asleep?	☐	☐	☐	☐	☐	☐
awaken too early in the morning and couldn't get back to sleep?	☐	☐	☐	☐	☐	☐
have fearful thoughts or images as you are falling asleep?	☐	☐	☐	☐	☐	☐
have nightmares or bad dreams during the night?	☐	☐	☐	☐	☐	☐
walk in your sleep?	☐	☐	☐	☐	☐	☐
have a good night's sleep?	☐	☐	☐	☐	☐	☐
wet your bed?	☐	☐	☐	☐	☐	☐
wake up once during the night?	☐	☐	☐	☐	☐	☐
wake up more than once during the night?	☐	☐	☐	☐	☐	☐
snore?	☐	☐	☐	☐	☐	☐
snore loudly?	☐	☐	☐	☐	☐	☐
stop breathing while you sleep or wake up gasping for breath?	☐	☐	☐	☐	☐	☐
feel satisfied with your sleep?	☐	☐	☐	☐	☐	☐

30. Have you ever been unable to move when falling asleep or immediately upon waking?
☐ Yes ☐ No ☐ Don't know

31. Have you ever had episodes of sudden muscular weakness (paralysis, inability to move) when laughing, angry, or in other emotional situations? ☐ Yes ☐ No ☐ Don't know

DAYTIME SLEEPINESS

32. People sometimes feel sleepy during the daytime. During your daytime activities, how much of a problem do you have with sleepiness (feeling sleepy, struggling to stay awake)?
☐ no problem at all ☐ a little problem ☐ more than a little problem
☐ a big problem ☐ a very big problem

33. Some people take naps in the daytime every day, others never do. When do you nap? (check all that apply)
☐ I never nap ☐ I nap every day ☐ I sometimes nap on school days
☐ I sometimes nap on weekends ☐ I never nap unless I am sick

34. During the last two weeks, have you struggled to stay awake (fought sleep) and/or fallen asleep in the following situations? (Check one answer for every item)

	No	Struggled to stay awake (fount sleep)	Fallen asleep	Does not apply
In a face-to-face conversation with another person?...	☐	☐	☐	☐
Traveling in a bus, train, place or car?.....	☐	☐	☐	☐
Attending a performance (movie, concert, play)?.....	☐	☐	☐	☐
Watching television?.....	☐	☐	☐	☐
Reading, studying, or doing homework?	☐	☐	☐	☐
During a test?.....	☐	☐	☐	☐
Driving a car?.....	☐	☐	☐	☐
In a class at school?	☐	☐	☐	☐
While doing work on a computer or typewriter?	☐	☐	☐	☐
Playing video games?.....	☐	☐	☐	☐
Riding a bicycle?.....	☐	☐	☐	☐
Eating a meal?	☐	☐	☐	☐

35. **Complete only if you have a driver's license:**
Have you ever had a car accident(s) caused by your sleepiness (not due to alcohol or drugs)?
☐ Yes ☐ No ☐ Don't know

Have you ever had a near car accident(s) ("close calls") caused by your sleepiness (not due to alcohol or drugs)? ☐ Yes ☐ No ☐ Don't know

In the past month, how often have you driven while sleepy?
☐ never ☐ 1-2 times ☐ 3-4 times ☐ 5 or more times

SLEEP/WAKE RHYTHMS: For items 36-45, please check the response for each item that best describes you.

36. Considering only your own "feeling best" rhythm, at what time would you get up if you were entirely free to plan your day?
☐ 5:00-6:30 AM ☐ 6:30-7:45 AM ☐7:45-9:45 AM
☐ 9:45-11 AM ☐ 11:00 AM-12:00 PM (noon)

37. Considering only your own "feeling best" rhythm, at what time would you go to bed if you were entirely free to plan your evening?
☐ 8:00-9:00 PM ☐ 9:00-10:15 PM ☐ 10:15 PM-12:30 AM
☐ 12:30-1:45 AM ☐ 1:45-3:00 AM

38. Assuming normal circumstances, how easy do you find getting up in the morning? (check one)
☐ Not at all easy ☐ Slightly easy
☐ Fairly easy ☐ Very easy

39. How alert do you feel during the first half hour after having awakened in the morning? (check one)
☐ Not at all alert ☐ Slightly alert
☐ Fairly alert ☐ Very alert

40. During the first half hour after having awakened in the morning, how tired do you feel? (check one)
☐ Not at all tired ☐ Fairly tired
☐ Fairly refreshed ☐ Very refreshed

41. At what time in the evening do you feel tired and as a result in need of sleep?
☐ 8:00-9:00 PM ☐ 9:00-10:15 PM ☐ 10:15 PM-12:30 AM
☐ 12:30-1:45 AM ☐ 1:45-3:00 AM

42. The bad news: you have to take a two-hour test. The good news: you can take it when you think you'll do your best. What time is that? Considering only your own "feeling best" rhythm, at what time would you go to bed if you were entirely free to plan your evening?
☐ 8:00-10:00 AM ☐ 11:00 AM-1:00 PM
☐ 3:00-5:00 PM ☐ 7:00-9:00 PM

43. One hears about "morning" and "evening" types of people. Which ONE of these types do you consider yourself to be? (check one)
☐ Definitely a morning type ☐ More a morning type than evening type
☐ More an evening type than morning type ☐ Definitely an evening type

44. If you always had to rise at 6:00 AM, what do you think it would be like? (check one)
☐ Very difficult and unpleasant ☐ Rather difficult and unpleasant
☐ A little unpleasant but no great problem ☐ Easy and not unpleasant

45. How long does it usually take before you "recover your senses" in the morning after rising from a night's sleep? (check one)
☐ 0-10 minutes ☐ 11-20 minutes
☐ 21-40 minutes ☐ More than 40 minutes

SCHOOL INFORMATION: The next set of questions are about school and other activities.
46. What grade are you in?
☐ 4 ☐5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐12

47. Are your grades in school mostly?
☐ A's ☐ A's & B's ☐ B's
☐ B's & C's ☐ C's ☐ C's & D's
☐ D's ☐ D's and F's

48. What is the highest grade in school you expect to complete? (check one)
☐ may not finish high school ☐ will finish high school
☐ will get a college degree ☐ will get a degree beyond college

49. During the last 2 weeks, did you work at a job for pay? ☐ Yes ☐ No (If no skip to item 50)
What kind of job? _____

On average, how many hours did you work at your paying job per week:
during school week: _____ hours during the weekend: _____ hours

50. During the last 2 weeks, did you engage in organized sports or a regularly scheduled physical activity?
☐ Yes ☐ No (If no skip to item 51)

What kind of sport or activity? _____

On average, how many hours did you practice per week:
during school week: _____ hours during the weekend: _____ hours

51. During the last 2 weeks, did you participate in organized extracurricular activities? (For example, committees, clubs, volunteer work, musical groups, church groups, etc.)
☐ Yes ☐ No (If no skip to item 52)
What kind of sport or activity? _____

On average, how many hours did you work at your paying job per week:
during school week: _____ hours during the weekend: _____ hours

52. During the last 2 weeks, did you study/do homework? ☐ Yes ☐ No

On average, how many hours per week:
during school week: _____ hours during the weekend: _____ hours

53. Generally, how often do you attend school?
a. ☐ Every day
b. ☐ 3-4 days per week
c. ☐ 1-2 days per week
d. ☐ Less than once per week

54. Generally, how often are you late to school?
a. ☐ Every day
b. ☐ 3-4 days per week
c. ☐ 1-2 days per week
d. ☐ Less than once per week

HEALTH INFORMATION

(Questions 54-58 are about changes that may be happening to your body. These changes normally happen to different young people at different ages. If you do not understand a question or do not know the answer, just check "I don't know".)

55. Would you say that your growth in height? (check one)
☐ has not begun to spurt ("spurt" means faster growth than usual) ☐ has barely started
☐ is definitely underway ☐ seems complete
☐ I don't know

56. And how about the growth of your body hair? ("Body hair" means hair any place other than your head, such as under your arms). Would you say that your body hair grown: (check one)
☐ has not yet started to grow ☐ has barely started to grow
☐ is definitely underway ☐ seems completed
☐ I don't know

57. Have you noticed any skin changes, especially pimples: (check one)
☐ skin has not yet started changing ☐ skin has barely started changing
☐ skin changes are definitely underway ☐ skin changes seem complete
☐ I don't know

58. Compared to other people your age, would you say that your health is:
☐ poor ☐ fair ☐ good ☐ excellent

59. During the last 2 weeks, how many days did you stay home from school because you were:
sick?: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Does not apply
other?: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Does not apply

Why did you stay home from school? _____

HEALTH HABITS: Please answer the following questions about health habits that can have effects on sleep.

60. During the LAST MONTH

How much did you use tobacco products?
☐ More than 1 pack (20 cigarettes) per day ☐ Between 5 and 20 cigarettes per day
☐ Between 1 and 5 cigarettes per day ☐ Less than 1 cigarette per day
☐ None

If you smoke, at what time do you usually have your last cigarette of the day _____☐ AM/ ☐ PM

How much coffee did you drink?
☐ More than 3 glasses per day ☐ Between 1 and 3 glasses per day
☐ Less than one glass per day None

How much caffeinated soda did you drink?
☐ More than 3 glasses per day ☐ Between 1 and 3 glasses per day
☐ Less than one glass per day None

SLEEP BELIEFS

61. In order to better understand your sense of the average teenager's sleep, please answer the following questions based on your beliefs for an **average** adolescent who does **not** have sleep problems?
How many hours of sleep per night does the average teenager get? _____ hours
How long does it take the average teenager to get to sleep? _____ minutes
How many times does the average teenager wake up during the night? _____ times

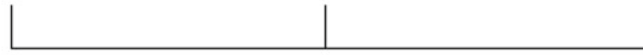
How long does the average teenager spend awake in bed during the night?
____minutes **OR** ____hours
Do you think most teenagers get enough sleep? ☐ Yes ☐ No ☐ Don't Know

Please indicate how important the **average** teenager **thinks** the following health habits are:
(Please put an X on the line)

using sun screen

Not Important | Somewhat important | Very important

avoiding high fat foods



Not Important | Somewhat important | Very important

not driving after drinking alcohol

Not Important | Somewhat important | Very important

not driving while drowsy

Not Important | Somewhat important | Very important

getting a good night's sleep

Not Important | Somewhat important | Very important

not smoking cigarettes

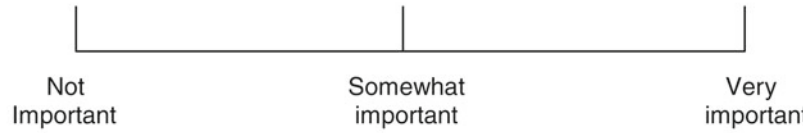
Not Important | Somewhat important | Very important

exercising regularly

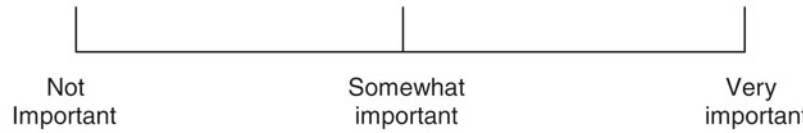
Not Important | Somewhat important | Very important

SLEEP BELIEFS (continued)
Please indicate how likely the **average** teenager is to **do** the following are: (Please put an X on the line)

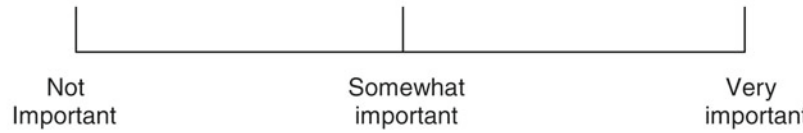
use sun screen



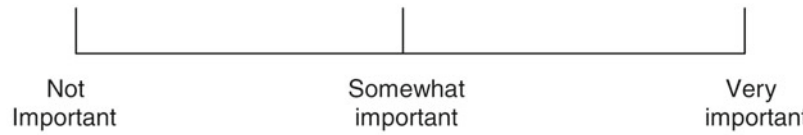
avoid high fat foods



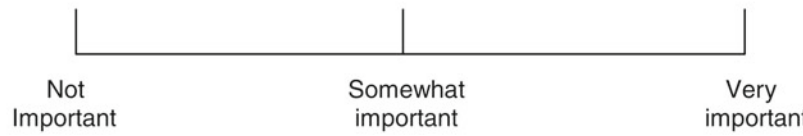
not driving after drinking alcohol



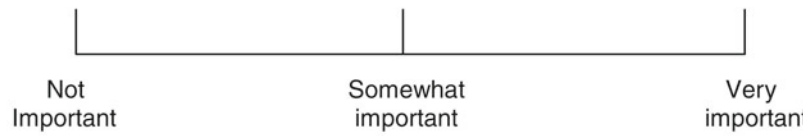
not driving while drowsy



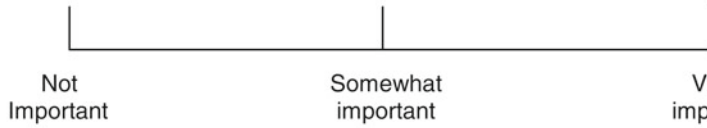
getting a good night's sleep



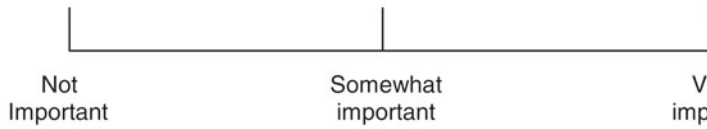
not smoking cigarettes



not using drugs



exercising regularly



THANK YOU VERY MUCH FOR YOUR TIME!

ADOLESCENT SLEEP HABITS SURVEY
(GIRL'S SELF REPORT)

Instructions: This form should be filled out by the adolescent patient herself if at all possible.
Today's Date: _____/_____/_____

1. Name:_____2. Date of Birth: ____/____/____
3. Please describe your sleep problem(s): _____
_____
_____

4. How long have you had difficulty with sleep? (check one)
☐ less than a month ☐ 1-6 months
☐ 6-12 months ☐ 1-5 years
☐ more than 5 years

5. Have your problems with sleep gotten worse? ☐ Yes ☐ No ☐Not sure
If yes, when did you notice that your sleep problems got worse: _____

6. What do you think is causing your sleep problem? (check all that apply)
☐ stress at school ☐ relationship problems with parents/family
☐ relationship problems with peers ☐ poor sleep habits
☐ poor eating habits ☐ a physical problem
Other (describe briefly)_____

SLEEP HABITS: This set of questions asks about your usual sleep habits. Please answer as honestly as possible.

7. With whom do you share a bedroom? (check all that apply)

	Yes	No
Mother/step-mother	☐	☐
Father/step-father	☐	☐
Older brother(s)/sister(s)	☐	☐
Younger brother(s)/sister(s)	☐	☐
Other family member(s).....	☐	☐

8. In the last two weeks, have you slept in the same bed?
☐ every night ☐ almost every night
☐ a few nights ☐ not at all

The next set of questions has to do with your usual schedule on days when you have school. Please list both the USUAL times or number of hours/minutes, and the RANGE (earliest to latest, lowest to highest). Please check AM or PM for each time.

9. What time do you **usually** go to bed on school days? _____
Range: _____ ☐ AM/ ☐ PM to _____ ☐ AM/ ☐ PM

SLEEP HABITS (continued)

10. There are many reasons for doing things at one time or another. What is the **main reason** you usually go to bed at this time on school days? (check one)

☐ My parents have set my bedtime
☐ I finish my homework
☐ My brother(s) or sister(s) go to bed
☐ I get home from my job
☐ I feel sleepy
☐ My TV shows are over
☐ I finish socializing
☐ Other: _____

11. What time do you **usually** wake up on school days? _____
Range: _____ ☐AM/ ☐PM to _____ ☐AM/ ☐ PM

12. There are many reasons for doing things at one time or another. What is the **main reason** you usually wake up at this time on school days? (check one)

☐ Noises or my pet wakes me up
☐ My parents wake me up
☐ I don't know, I just wake up
☐ My alarm clock wakes me up
☐ I need to go to the bathroom
☐ Other: _____

13. What time do you **usually** leave home on school days? _____
Range: _____ ☐AM/ ☐ PM to _____ ☐AM/ ☐ PM

14. How do you usually get to school? (check one)
☐ Walk ☐ Take the bus ☐ Get a ride with parent
☐ Get a ride with friend(s) ☐ Drive my car

What time do you need to arrive at school? _____

15. Figure out how long you **usually** sleep on a normal school night and fill it in here. (Do not include time you spend awake in bed. Remember to mark hours and minutes, even if minutes are zero.)
Usual amount of sleep: _____ hours and_____ minutes
Range: _____ hours and_____ minutes to _____ hours and_____ minutes

16. On school days, after you go to bed at night, about how long does it usually take you to fall asleep? (If longer than one hour, change to minutes.)
Usual amount: _____ minutes
Range: _____ minutes to _____ minutes

The next set of questions has to do with your usual schedule on days when you DO NOT have school, such as the weekend.

17. What time do you **usually** go to bed on weekends? _____
Range: _____ ☐AM/ ☐PM to _____ ☐AM/ ☐ PM

18. There are many reasons for doing things at one time or another. What is the **main reason** you usually go to bed at this time on **weekends**? (check one)
☐My parents have set my bedtime
☐ I finish my homework
☐ My brother(s) or sister(s) go to bed
☐ I get home from my job
☐ I feel sleepy
☐ My TV shows are over
☐ I finish socializing
☐ Other: _____

SLEEP HABITS (continued)

19. What time do you **usually** wake up on weekends? _____ ☐AM/ ☐PM
Range: _____ ☐ AM/ ☐PM to _____ ☐AM/ ☐ PM

20. What is the **main reason** you usually wake up at this time on weekends? (check one)

☐ Noises or my pet wakes me up
☐ My alarm clock wakes me up
☐ My parents wake me up
☐ I need to go to the bathroom
☐ I don't know, I just wake up
☐ Other: _____

21. Figure out how long you **usually** sleep on a night when you do not have school the next day (such as a weekend night) and fill it in here. (Do not include time you spend awake in bed. Remember to mark hours and minutes, even if minutes are zero.)
Usual amount of sleep: _____ hours and_____ minutes
Range: _____ hours and_____ minutes to _____ hours and_____ minutes

22. On weekends, after you go to bed at night, about how long does it usually take you to fall asleep? (If longer than one hour, change to minutes.)
Range: _____ minutes to _____ minutes

23. Can you figure out how much sleep you need? Fill out how much sleep you think you would need each night to feel your best every day. (Do not include time you spend awake in bed. Remember to mark hours and minutes, even if minutes are zero.)
_____ hours _____ minutes

The following questions ask about other sleep habits you may have. Please answer as honestly as possible.

24. In the last two weeks, how often have you done any of the following activities in bed?

	Every day/night	Several times	Twice	Once	Never
Read?	☐	☐	☐	☐	☐
Watch TV?	☐	☐	☐	☐	☐
Eat?	☐	☐	☐	☐	☐
Do schoolwork?	☐	☐	☐	☐	☐
Worry?	☐	☐	☐	☐	☐

25. When you have difficulty falling asleep or getting back to sleep, what do you do? (check all that apply)

☐ Stay in bed and try to get to sleep
☐ Do something in bed (e.g., read or watch TV)
☐ Get up and watch TV
☐ Get up and drink alcohol
☐ Get up and drink warm milk
☐ Get up and drink something? (circle all that apply: soda/water/coffee/tea)
☐ Get up and have a cigarette
Other (please specify): _____

SLEEP HABITS (continued)

26. Please circle a number from 1-10 to indicate how much difficulty you have relaxing away tension in your body while trying to sleep.

0	1	2	3	4	5	6	7	8	9	10
No Difficulty					Some Difficulty					Great Difficulty

27. Please circle a number from 1-10 to indicate how much difficulty you have in "slowing down" or "turning off" your mind while trying to sleep.

0	1	2	3	4	5	6	7	8	9	10
No Difficulty					Some Difficulty					Great Difficulty

28. Do you currently use medications (over-the-counter or prescription) to help you sleep?
☐Yes ☐ No

If yes, how often (check one):
☐ once a month or less ☐ once a week or less ☐ few times a week ☐ nightly

Please list any medications you are currently using (within the past month) to help you sleep:

Name of Medication	Amount	How long have you used this medicine?	Meds make you feel		
			Better	No Change	Worse
_____			☐	☐	☐
_____			☐	☐	☐
_____			☐	☐	☐

If you are not currently using medication to help you sleep, have you ever used medication in the past (over-the-counter or prescription) to help you sleep? ☐ Yes ☐ No

If yes, list any medications you used to help you sleep:

Name of Medication	Amount	How long did you use medicine?	Meds make you feel		
			Better	No Change	Worse
_____			☐	☐	☐
_____			☐	☐	☐
_____			☐	☐	☐

SLEEP HISTORY (GENERAL)

29. In an average 2 week period, how often do you... (Check **ONE** answer for each question)

	Every day/night	5-6 times	3-4 times	1-2 times	Never	Don't know
need more than one reminder to get up in the morning?	☐	☐	☐	☐	☐	☐
arrive late to class because you overslept?	☐	☐	☐	☐	☐	☐
fall asleep in a morning class?	☐	☐	☐	☐	☐	☐
fall asleep in a afternoon class?	☐	☐	☐	☐	☐	☐
feel tired, dragged out, or sleepy during the day?	☐	☐	☐	☐	☐	☐
go to bed because you just could not stay awake any longer?	☐	☐	☐	☐	☐	☐
sleep in past noon?	☐	☐	☐	☐	☐	☐
stay up until at least 3 am?	☐	☐	☐	☐	☐	☐
stay up all night?	☐	☐	☐	☐	☐	☐
have an extremely hard time falling asleep?	☐	☐	☐	☐	☐	☐
awaken too early in the morning and couldn't get back to sleep?	☐	☐	☐	☐	☐	☐
have fearful thoughts or images as you are falling asleep?	☐	☐	☐	☐	☐	☐
have nightmares or bad dreams during the night?	☐	☐	☐	☐	☐	☐
walk in your sleep?	☐	☐	☐	☐	☐	☐
have a good night's sleep?	☐	☐	☐	☐	☐	☐
wet your bed?	☐	☐	☐	☐	☐	☐
wake up once during the night?	☐	☐	☐	☐	☐	☐
wake up more than once during the night?	☐	☐	☐	☐	☐	☐
snore?	☐	☐	☐	☐	☐	☐
snore loudly?	☐	☐	☐	☐	☐	☐
stop breathing while you sleep or wake up gasping for breath?	☐	☐	☐	☐	☐	☐
feel satisfied with your sleep?	☐	☐	☐	☐	☐	☐

30. Have you ever been unable to move when falling asleep or immediately upon waking?
☐ Yes ☐ No ☐ Don't know

31. Have you ever had episodes of sudden muscular weakness (paralysis, inability to move) when laughing, angry, or in other emotional situations? ☐ Yes ☐ No ☐ Don't know

DAYTIME SLEEPINESS

32. People sometimes feel sleepy during the daytime. During your daytime activities, how much of a problem do you have with sleepiness (feeling sleepy, struggling to stay awake)?
☐ no problem at all ☐ a little problem ☐ more than a little problem
☐ a big problem ☐ a very big problem

33. Some people take naps in the daytime every day, others never do. When do you nap? (check all that apply)
☐ I never nap ☐ I nap every day ☐ I sometimes nap on school days
☐ I sometimes nap on weekends ☐ I never nap unless I am sick

34. During the last two weeks, have you struggled to stay awake (fought sleep) and/or fallen asleep in the following situations? (Check one answer for every item)

	No	Struggled to stay awake (fount sleep)	Fallen asleep	Does not apply
In a face-to-face conversation with another person?...	☐	☐	☐	☐
Traveling in a bus, train, place or car?.....	☐	☐	☐	☐
Attending a performance (movie, concert, play)?.....	☐	☐	☐	☐
Watching television?.....	☐	☐	☐	☐
Reading, studying, or doing homework?	☐	☐	☐	☐
During a test?.....	☐	☐	☐	☐
Driving a car?.....	☐	☐	☐	☐
In a class at school?	☐	☐	☐	☐
While doing work on a computer or typewriter?	☐	☐	☐	☐
Playing video games?.....	☐	☐	☐	☐
Riding a bicycle?.....	☐	☐	☐	☐
Eating a meal?	☐	☐	☐	☐

35. **Complete only if you have a driver's license:**
Have you ever had a car accident(s) caused by your sleepiness (not due to alcohol or drugs)?
☐ Yes ☐ No ☐ Don't know

Have you ever had a near car accident(s) ("close calls") caused by your sleepiness (not due to alcohol or drugs)? ☐ Yes ☐ No ☐ Don't know

In the past month, how often have you driven while sleepy?
☐ never ☐ 1-2 times ☐ 3-4 times ☐ 5 or more times

SLEEP/WAKE RHYTHMS: For items 36-45, please check the response for each item that best describes you.

36. Considering only your own "feeling best" rhythm, at what time would you get up if you were entirely free to plan your day?
☐ 5:00-6:30 AM ☐ 6:30-7:45 AM ☐7:45-9:45 AM
☐ 9:45-11 AM ☐ 11:00 AM-12:00 PM (noon)

37. Considering only your own "feeling best" rhythm, at what time would you go to bed if you were entirely free to plan your evening?
☐ 8:00-9:00 PM ☐ 9:00-10:15 PM ☐ 10:15 PM-12:30 AM
☐ 12:30-1:45 AM ☐ 1:45-3:00 AM

38. Assuming normal circumstances, how easy do you find getting up in the morning? (check one)
☐ Not at all easy ☐ Slightly easy
☐ Fairly easy ☐ Very easy

39. How alert do you feel during the first half hour after having awakened in the morning? (check one)
☐ Not at all alert ☐ Slightly alert
☐ Fairly alert ☐ Very alert

40. During the first half hour after having awakened in the morning, how tired do you feel? (check one)
☐ Not at all tired ☐ Fairly tired
☐ Fairly refreshed ☐ Very refreshed

41. At what time in the evening do you feel tired and as a result in need of sleep?
☐ 8:00-9:00 PM ☐ 9:00-10:15 PM ☐ 10:15 PM-12:30 AM
☐ 12:30-1:45 AM ☐ 1:45-3:00 AM

42. The bad news: you have to take a two-hour test. The good news: you can take it when you think you'll do your best. What time is that? Considering only your own "feeling best" rhythm, at what time would you go to bed if you were entirely free to plan your evening?
☐ 8:00-10:00 AM ☐ 11:00 AM-1:00 PM
☐ 3:00-5:00 PM ☐ 7:00-9:00 PM

43. One hears about "morning" and "evening" types of people. Which ONE of these types do you consider yourself to be? (check one)
☐ Definitely a morning type ☐ More a morning type than evening type
☐ More an evening type than morning type ☐ Definitely an evening type

44. If you always had to rise at 6:00 AM, what do you think it would be like? (check one)
☐ Very difficult and unpleasant ☐ Rather difficult and unpleasant
☐ A little unpleasant but no great problem ☐ Easy and not unpleasant

45. How long does it usually take before you "recover your senses" in the morning after rising from a night's sleep? (check one)
☐ 0-10 minutes ☐ 11-20 minutes
☐ 21-40 minutes ☐ More than 40 minutes

SCHOOL INFORMATION: The next set of questions are about school and other activities.
46. What grade are you in?
☐ 4 ☐5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐12

47. Are your grades in school mostly?
☐ A's ☐ A's & B's ☐ B's
☐ B's & C's ☐ C's ☐ C's & D's
☐ D's ☐ D's and F's

48. What is the highest grade in school you expect to complete? (check one)
☐ may not finish high school ☐ will finish high school
☐ will get a college degree ☐ will get a degree beyond college

49. During the last 2 weeks, did you work at a job for pay? ☐ Yes ☐ No (If no skip to item 50)
What kind of job? _____

On average, how many hours did you work at your paying job per week:
during school week: _____ hours during the weekend: _____ hours

50. During the last 2 weeks, did you engage in organized sports or a regularly scheduled physical activity?
☐ Yes ☐ No (If no skip to item 51)

What kind of sport or activity? _____

On average, how many hours did you practice per week:
during school week: _____ hours during the weekend: _____ hours

51. During the last 2 weeks, did you participate in organized extracurricular activities? (For example, committees, clubs, volunteer work, musical groups, church groups, etc.)
☐ Yes ☐ No (If no skip to item 52)
What kind of sport or activity? _____

On average, how many hours did you work at your paying job per week:
during school week: _____ hours during the weekend: _____ hours

52. During the last 2 weeks, did you study/do homework? ☐ Yes ☐ No

On average, how many hours per week:
during school week: _____ hours during the weekend: _____ hours

53. Generally, how often do you attend school?
a. ☐ Every day
b. ☐ 3-4 days per week
c. ☐ 1-2 days per week
d. ☐ Less than once per week

54. Generally, how often are you late to school?
a. ☐ Every day
b. ☐ 3-4 days per week
c. ☐ 1-2 days per week
d. ☐ Less than once per week

HEALTH INFORMATION

(Questions 54-58 are about changes that may be happening to your body. These changes normally happen to different young people at different ages. If you do not understand a question or do not know the answer, just check "I don't know".)

55. Would you say that your growth in height? (check one)
☐ has not begun to spurt ("spurt" means faster growth than usual) ☐ has barely started
☐ is definitely underway ☐ seems complete
☐ I don't know

56. And how about the growth of your body hair? ("Body hair" means hair any place other than your head, such as under your arms). Would you say that your body hair grown: (check one)
☐ has not yet started to grow ☐ has barely started to grow
☐ is definitely underway ☐ seems completed
☐ I don't know

57. Have you noticed any skin changes, especially pimples: (check one)
☐ skin has not yet started changing ☐ skin has barely started changing
☐ skin changes are definitely underway ☐ skin changes seem complete
☐ I don't know

58. Have you noticed that your breasts have begun to grow: (check one)
☐ have not yet started growing ☐ have barely started changing
☐ breast growth is definitely underway ☐ breast growth seems completed
☐ I don't know

59. Have you begun to menstruate (started your period)? ☐ Yes ☐ No
If yes how old were you (years):
☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ Older than 16 ☐ I don't know

60. Compared to other people your age, would you say that your health is:
☐ poor ☐ fair ☐ good ☐ excellent

61. During the last 2 weeks, how many days did you stay home from school because you were:
sick?: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Does not apply
other?: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Does not apply

Why did you stay home from school? _____

HEALTH HABITS: Please answer the following questions about health habits that can have effects on sleep.

62. During the LAST MONTH

How much did you use tobacco products?
☐ More than 1 pack (20 cigarettes) per day ☐ Between 5 and 20 cigarettes per day
☐ Between 1 and 5 cigarettes per day ☐ Less than 1 cigarette per day
☐ None

If you smoke, at what time do you usually have your last cigarette of the day _____☐ AM/ ☐ PM

How much coffee did you drink?
☐ More than 3 glasses per day ☐ Between 1 and 3 glasses per day
☐ Less than one glass per day None

How much caffeinated soda did you drink?
☐ More than 3 glasses per day ☐ Between 1 and 3 glasses per day
☐ Less than one glass per day None

SLEEP BELIEFS

63. In order to better understand your sense of the average teenager's sleep, please answer the following questions based on your beliefs for an **average** adolescent who does **not** have sleep problems?
How many hours of sleep per night does the average teenager get? _____ hours
How long does it take the average teenager to get to sleep? _____ minutes
How many times does the average teenager wake up during the night? _____ times

How long does the average teenager spend awake in bed during the night?
____minutes **OR** ____hours
Do you think most teenagers get enough sleep? ☐ Yes ☐ No ☐ Don't Know

Please indicate how important the **average** teenager **thinks** the following health habits are:
(Please put an X on the line)

using sun screen

Not Important | Somewhat important | Very important

avoiding high fat foods

Not Important | Somewhat important | Very important

not driving after drinking alcohol

Not Important | Somewhat important | Very important

not driving while drowsy

Not Important | Somewhat important | Very important

getting a good night's sleep

Not Important | Somewhat important | Very important

not smoking cigarettes

Not Important | Somewhat important | Very important

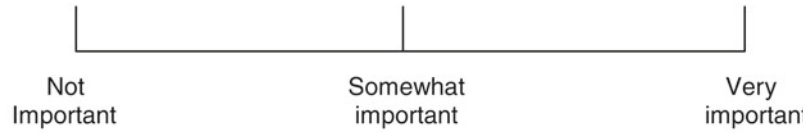
exercising regularly

Not Important | Somewhat important | Very important

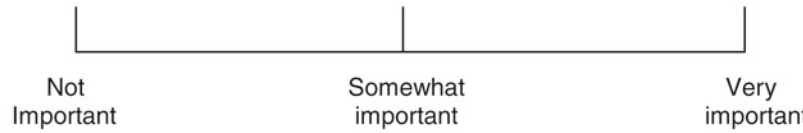
SLEEP BELIEFS (continued)

Please indicate how likely the **average** teenager is to **do** the following are: (Please put an X on the line)

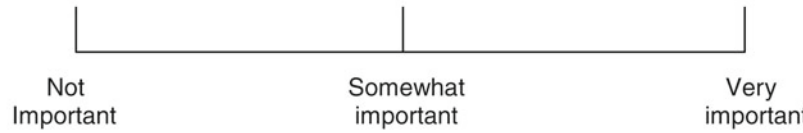
use sun screen



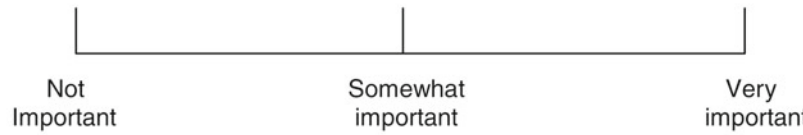
avoid high fat foods



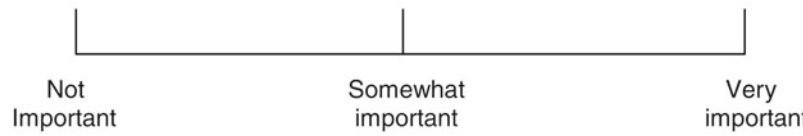
not driving after drinking alcohol



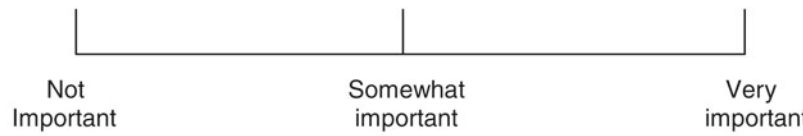
not driving while drowsy



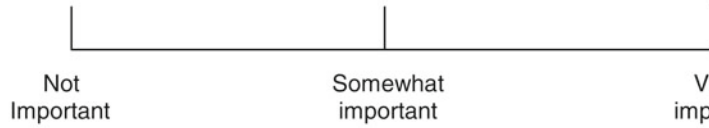
getting a good night's sleep



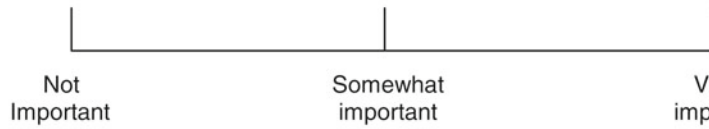
not smoking cigarettes



not using drugs



exercising regularly



THANK YOU VERY MUCH FOR YOUR TIME!

ADOLESCENT SLEEP HABITS SURVEY (PARENT VERSION)

1. Name of Patient: _____2. Date of Birth:___/___/___
3. Name of person completing questionnaire_____
   Relationship to child _____
   Referred by _____
   Pediatrician _____
4. A copy of the sleep clinic evaluation will be sent to you, your pediatrician, and any referring physician. Please indicate anyone else who should receive a copy:
Name: _____ Address: _____
_____
5. What are your major concerns about your adolescent's sleep?_____
_____
_____
6. What do you think is causing your adolescent's sleep problem?_____
_____
7. When did your adolescent's sleep problems start? _____
_____

FAMILY INFORMATION

8. Please list all members of the households in which your adolescent lives full or part-time:

Name/Relationship to Adolescent	Age	Adolescent lives with (please indicate full-time or part-time)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

9. Mother's Marital Status: Married Divorced Separated Widowed Single
If divorced, adolescent custody with: _____
10. Mother's education: _____
11. Mother's occupation: _____
    Does mother work outside of home? ☐ yes ☐ no
    If yes, mark each label that best describes her work:
    ☐ day shift ☐ full time
    ☐ evening shift ☐ part time
    ☐ night shift (graveyard) ☐ one job
    ☐ changing shifts ☐ more than one job

12. Father's Marital Status: Married Divorced Separated Widowed Single
If divorced, adolescent custody with: _____
13. What is father's education: _____

14. Father's occupation: _____

Does father work outside of home? Yes No

If yes, mark each label that best describes his work:

☐day shift ☐ full time

☐evening shift ☐ part time

☐ night shift (graveyard) ☐ one job

☐ changing shifts ☐ more than one job

15. What best describes your adolescent's racial/ethnic background?

White/Caucasian_____ Asian/Asian American _____

Black/African American _____ Native American _____

Hispanic/Latino _____ Multiracial (Please specify)_____

Other (Please specify)_____

16. Please list family members (parents, grandparents, siblings, aunts/uncles) with a history of any SLEEP PROBLEMS (including: loud snoring/obstructive sleep apnea, excessive sleepiness/narcolepsy, restless legs/periodic leg movements, insomnia, other sleep problems).

Family Member	Type of Sleep Problem
_____	_____
_____	_____
_____	_____
_____	_____

17. Has anyone in your family ever had a car accident caused by sleepiness (not due to alcohol or drugs)? ☐Yes ☐No ☐Don't know

If yes, whom: _____At what age:_____

Type of accident: _____

18. Please list any family members with a significant mental health condition (such as depression, anxiety, alcoholism/substance abuse).

Family Member	Type of Mental Health Problem
_____	_____
_____	_____
_____	_____

SLEEP HISTORY (GENERAL)

19. What time does your adolescent usually go to bed on school nights? _____

Range: _____ am/pm to _____am/pm

20. What is the main reason your adolescent goes to bed at a particular time? (Check one below)

_____ a. Because it fits best with the family's schedule

_____ b. Because she/he feels sleepy then

_____ c. Because that is when her/his TV shows are over

_____ d. Because that is when her/his brothers and sisters go to bed

_____ e. To "get enough sleep" for the following day's activities

_____ f. Other (describe briefly) _____

21. What time does your adolescent usually wake up on school day mornings? _____

Range: _____ am/pm to _____am/pm

22. What usually wakes up your adolescent in the morning on school days? (Check one below)

_____ a. Alarm clock
_____ b. Parent or other family member
_____ c. Noise
_____ d. Needs to go to the bathroom
_____ e. Spontaneous
_____ f. Other (describe briefly):

23. Which of the following applies to waking your adolescent in the morning on school days?
(Check one below)

_____ a. I almost always have great difficulty getting him/her out of bed
_____ b. I sometimes have great difficulty getting him/her our of bed
_____ c. I seldom have great difficulty getting him/her out of bed
_____ d. I never have great difficulty getting him/her out of bed

24. What times does your adolescent usually go to bed on weekend nights? _____
Range: _____ am/pm to_____am/pm

25. What time does your adolescent usually wake up on weekend mornings? _____
Range: _____ am/pm to _____am/pm

26. What usually wakes up your adolescent in the morning on weekends? (Check one below)

_____ a. Alarm clock
_____ b. Parent or other family member
_____ c. Noise
_____ d. Needs to go to the bathroom
_____ e. Spontaneous
_____ f. Other (describe briefly):

27. Which of the following applies to waking your adolescent in the morning on weekends?
(Check one below)

_____ a. I almost always have great difficulty getting him/her out of bed
_____ b. I sometimes have great difficulty getting him/her our of bed
_____ c. I seldom have great difficulty getting him/her out of bed
_____ d. I never have great difficulty getting him/her out of bed

28. IN AN AVERAGE TWO-WEEK PERIOD, HOW OFTEN DOES YOUR ADOLESCENT...
(Check one answer for each question; please feel free to comment)

	Every day/ night	**5-6 times**	**3-4 times**	**1-2 times**	**Never**	**Comments:**
snore?	☐	☐	☐	☐	☐	_____
snore loudly and disruptively?	☐	☐	☐	☐	☐	_____
sleep restlessly?	☐	☐	☐	☐	☐	_____
sleep in an abnormal position?	☐	☐	☐	☐	☐	_____
sweat while sleeping?	☐	☐	☐	☐	☐	_____
pause in breathing?	☐	☐	☐	☐	☐	_____
complain of headache on waking?	☐	☐	☐	☐	☐	_____
have nightmares?	☐	☐	☐	☐	☐	_____
sleepwalk?	☐	☐	☐	☐	☐	_____
sleeptalk?	☐	☐	☐	☐	☐	_____

29. Has your adolescent ever used medication (over-the-counter or prescription) including herbal or "natural" remedies to help with sleep?

☐ Yes ☐ No ☐ Don't know

If yes, name of medication and how frequently used: _____

30. Does your adolescent currently (within the past month) use medications (over-the-counter or prescription) to help with sleep? ☐ Yes ☐ No ☐ Don't know

If yes, name of medication and how frequently used: _____

SLEEP HISTORY - DAYTIME SLEEPINESS

31. During the LAST TWO WEEKS, has your adolescent struggled to stay awake (fought sleep) or fallen asleep in the following situations? (Mark one answer for every item)

	No	Struggled to stay awake (fought sleep)	Fallen asleep	Don't Know	Does not Apply
a. in a face-to-face conversation with another person?	☐	☐	☐	☐	☐
b. traveling in a car, bus?	☐	☐	☐	☐	☐
c. at the movies?	☐	☐	☐	☐	☐
d. watching television?	☐	☐	☐	☐	☐
e. listening to the radio or stereo?	☐	☐	☐	☐	☐
f. reading, studying or doing homework?	☐	☐	☐	☐	☐
g. in a class at school?	☐	☐	☐	☐	☐
h. while doing work on a computer or typewriter?	☐	☐	☐	☐	☐
i. playing video games?	☐	☐	☐	☐	☐
j. eating a meal?	☐	☐	☐	☐	☐

MEDICAL HISTORY:

32. Were there any problems with this pregnancy or delivery (prematurity, high blood pressure, etc.)?

_____

_____

33. What was the birth weight? _____

34. Was your adolescent ever on an apnea monitor at home? ☐ Yes ☐ No

If yes, for how long? _____

35. Does your adolescent have any significant health problems? ☐ Yes ☐ No

If so, please describe:

_____

_____

36. Has your adolescent ever been hospitalized? ☐ Yes ☐ No

If yes, when: _____What for?_____

_____ _____

_____ _____

37. Has your adolescent ever had any operations (other than tonsils/adenoids removal)?
☐ Yes ☐ No
If yes, type of operation?_____ Year _____
_____Year _____
_____Year _____
38. Have your adolescent's tonsils or adenoids been removed?
a. Tonsils: ☐ Yes At what age?_____
For what reason: _____
b. Adenoids: ☐ Yes At what age?_____
For what reason: _____
c. Describe briefly any changes you noticed in your adolescent's sleep or waking behavior after removal of tonsils or adenoids: _____
39. If NO, do you think the tonsils or adenoids are a problem?
☐ Yes ☐ No ☐ Don't know
For how long have they been a problem? _____ years
40. Has your adolescent ever broken his/her nose or other facial bones? ☐ Yes ☐ No
41. Does your adolescent have difficulty breathing through his/her nose? ☐ Yes ☐ No
42. In the past year, has your adolescent had strep throats/tonsillitis? _____
☐ Yes ☐ No
Frequent colds/respiratory infections? ☐ Yes ☐ No
Frequent sinus infections? ☐ Yes ☐ No
43. Does your adolescent have allergies? ☐ Yes ☐ No ☐ Possibly
If yes, to what?_____
44. Does your adolescent have asthma? ☐ Yes ☐ No If "Yes", please answer the following questions:

In the **past year**....
a. How many days has your adolescent missed school due to asthma? _____ None
b. How many days has your adolescent been hospitalized for asthma? _____ None
c. List any medications your adolescent takes for asthma:

Type: _____ Frequency: _____
Type: _____ Frequency: _____
Type: _____ Frequency: _____

45. Does your adolescent frequently complain of heartburn? ☐ Yes ☐ No ☐ Don't know
Has he/she ever been diagnosed with gastroesophageal (stomach) reflux?
☐ Yes ☐ No ☐ Only when younger
46. Has your adolescent had any head injuries requiring medical evaluation and/or treatment or loss of consciousness? If yes, please describe:_____

47. List any prescription or over-the counter medications your adolescent has taken in the last month:
Type: _____ Reason for medication: _____
Type: _____ Reason for medication: _____
Type: _____ Reason for medication: _____

48. Menstrual history (Girls only):
a. Age she started menstruating _____ years
b. Regularity of her menstrual periods:
☐ About one per month (28 days)
☐ Usually much longer than one month between periods
☐ Usually shorter than one month between periods
☐ Very irregular; no apparent pattern
☐ Do not know
c. Number of days since her last menstrual period _____

49. Do you have additional comments about your adolescent's medical history? (Continue on additional sheets if necessary.)

_____

_____

_____

HEALTH HABITS - Please answer the following questions regarding health habits which may
impact on sleep.

50. In the past month, how much did your adolescent use tobacco products?
☐ More than one pack (20 cigarettes) per day
☐ Between 5 and 20 cigarettes per day
☐ Between 1 and 5 cigarettes per day
☐ Less than 1 cigarette per day
☐ None
☐ Don't know

51. How much coffee did your adolescent drink?
☐ More than 3 cups glasses per day
☐ Between 1 and 3 cups per day
☐ Less than one cup per day
☐ None
☐ Don't know

52. How much caffeinated soda did your adolescent drink?
☐ More than 3 glasses per day
☐ Between 1 and 3 per day
☐ Less than one per day
☐ None
☐ Don't know

53. How much time does your adolescent spend on the computer on school days?
☐ 0-2 hours per day ☐ between 2 and 4 hours ☐ between 4 and 6 hours
☐ between 6 and 8 hours ☐ more than 8 hours ☐ don't know

54. How much time does your adolescent spend on the computer on weekend days?
☐ 0-2 hours per day ☐ between 2 and 4 hours ☐ between 4 and 6 hours
☐ between 6 and 8 hours ☐ more than 8 hours ☐ don't know

DEVELOPMENT HISTORY- PART A

55. In what grade is your adolescent currently enrolled? _____ grade

56. What school does your adolescent attend this year?_____

57. Has your adolescent been diagnosed with:

	YES	NO	COMMENTS
a. dyslexia	☐	☐	_____
b. a speech impairment	☐	☐	_____
c. mental retardation	☐	☐	_____
d. a behavior disorder	☐	☐	_____
e. attention deficit disorder	☐	☐	_____
f. other learning disorder (please specify)_____	☐	☐	_____

58. Is your adolescent enrolled in any special education (special needs) classes in school?
☐ Yes ☐ No Please describe: _____

59. Does your adolescent have an Individualized Education Plan (I.E.P.) provided by the school? ☐ Yes ☐ No If yes, for what reason: _____

60. Generally, how often does your adolescent attend school?
   a. ☐ Every day
   b. ☐ 3-4 days per week
   c. ☐ 1-2 days per week
   d. ☐ Less than once per week

61. Generally, how often is your adolescent late to school?
   a. ☐ Every day
   b. ☐ 3-4 days per week
   c. ☐ 1-2 days per week
   d. ☐ Less than once per week

DEVELOPMENTAL HISTORY- PART B

62. Does your adolescent have any significant behavioral or mental health problems
☐ Yes ☐ No
If yes, please describe _____
_____

63. Has your adolescent ever received counseling for behavioral or mental health problems?
☐ Yes ☐ No If so, for what reason? _____
Please give approximate dates:
_____

64. Have you or your spouse ever been seen by a mental health counselor for concerns regarding your adolescent? ☐ Yes ☐ No
If yes, for what reason?_____

65. To what organized groups does your adolescent currently belong? (e.g., team sports, scouts, church, groups, etc.)

_____

_____

SLEEP BELIEFS

In order to better understand your sense of the average teenager's sleep, please answer the following questions based on your beliefs for an average teenager (your adolescent's age) who does not have sleep problems?

a. How many hours of sleep per night does the average teenager get? _____ hours
b. How long does it take the average teenager to get to sleep? _____ minutes
c. How many times does the average teenager wake up during the night? _____ times
d. How long does the average teenager spend awake in bed during the night?
_____ minutes or _____ hours
e. Do you think most teenagers get enough sleep? ☐ Yes ☐ No ☐ Don't Know

THANK YOU VERY MUCH FOR YOUR TIME!

Reference

1. KIDZZZSLEEP Pediatric Sleep Disorders Program. (April 3, 2009). *Clinical tools*. Retrieved June 17, 2009, from http://www.kidzzzsleep.org/clinicaltools.htm.

Representative Studies Using Scale

None.